Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS INJECTION AND DIAGNOSTICS
900 N CENTRAL EXPRESSWAY SUITE 550
DALLAS TX 75231

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

DALLAS ISD

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-04-8467-01

MFDR Date Received

APRIL 15, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In summary, it is our position that Risk Management Insurance has established an unfair and unreasonable time frame in paying the services that were pre-authorized and rendered to [injured employee]. The codes used to perform this procedure were not bundled and reimbursed at an unfair and unreasonable amount. Your reconsideration of our request to facilitate the payment of the claim is appreciated."

Amount in Dispute: $2,605.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated in Part III of the DWC-60: "4/26/04 – Allow code for DOS 9/4903 and no further recommendations – (NS)"

Response Submitted by: Dallas ISD Risk Management, 3700 Ross Ave., Box 91, Dallas, TX 75204

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 4, 2003	CPT Codes 76000, 99499, 99070. 97010. 99082, 99199	$1,080.35	$66.23
September 4, 2003	HCPCS Codes A4550, E0230, J3301, J3490, J7030, S9445	$369.95	$0.00
September 10, 2003	CPT Codes 76000-TC, 99499-RR, 99070 x 2, 97010, 99080	$1,340.70	$66.23
September 10, 2003	HCPCS Codes A4550, E0230, J3301, J3490, J7030, S9445	$369.95	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out guidelines for reimbursement of health care.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. This request for medical fee dispute resolution was received by the Division on April 15, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 20, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 26, 2004:
   - D91 – TWCC Code: D – Duplicate bill. This appears to be a duplicate charge.
   - G2 – TWCC Code: G – Unbundling (included in global). Per the National Correct Coding Policy, you can not unbundle codes when there is a code that is adequate for both procedure or included in the procedure.
   - G90 – TWCC Code: G – Unbundling (included in global). The value of these services is included in the value of another service billed on the same date.

Findings

1. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
2. According to the requestor, all services were preauthorized on August 11, 2003 with preauthorization number AP109154 for dates of service September 4 and 10, 2003.
3. In accordance with 28 Texas Administrative Code §134.202(b)(2)(A-C) and (b)(6) for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section; and (c)(1)To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L, 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule; if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection: For products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.
   - CPT Code 76000-TC – Fluoroscope Examination – Technical Component was billed on both dates of service; the insurance carrier did not reimburse the requestor for these services. The MAR for this service is $52.98 x 125% = $66.23 x 2 = $132.46; therefore reimbursement is recommended.
   - CPT Code 99070-ST is defined as special supplies. According to Medicare CCI edits payment for this service is always bundled into payment for other services not specified and no separate payment is made.
   - CPT Code 97010 is defined as hot or cold packs therapy. Payment for this service is always bundled into payment for other services not specified and no separate payment is made.
   - HCPCS Code E0230 – Ice cap or collar – requires one of three modifiers to determined payment. These modifiers are defined as NU – New; RR – Rental; or UE – Used. The requestor did not attach one of the listed modifiers; therefore, the Division cannot determine the payment for this code. Review of the reconsideration EOB shows that the requestor was reimbursed $6.25 for date of service September 10, 2003 and $0.00 for date of service September 4, 2003 for this DME; therefore, reimbursement is not recommended.

- HCPCS Code J3301 – Injection, triamcinolone acetonide is reimbursed at $1.60 x 125% per 10 mg. The requestor did not submit medical records to support the number of milligrams; therefore, the Division cannot determine the payment for this code. Review of the reconsideration EOB shows that the requestor was reimbursed $1.88 for date of service September 10, 2003 and $0.00 for date of service September 4, 2003 for this injection; therefore, reimbursement is not recommended.
- HCPCS Code J7030 – Infusion, normal saline solution, 1,000cc. This code is reimbursed at $10.77 x 125% per 1,000 cc's. The requestor billed 1 unit; however the requestor did not submit medical records to support the amount of saline solution used during the procedure; therefore, reimbursement is not recommended.

4. The following CPT and HCPCS codes relate to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission." Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
    - CPT Code 99499-RR – Unlisted E&M Service. The requestor did not submit documentation to support that the amount billed is a fair and reasonable amount. Therefore, reimbursement is not recommended.
    - CPT Code 99082 – Unusual Physician Travel. The requestor did not submit documentation to support that the amount billed is a fair and reasonable amount. Therefore, reimbursement is not recommended.
    - CPT Code 99199 – Special Service/Procedure/Report. This code was billed on date of service September 4, 2003. The requestor did not submit documentation to support that the amount billed is a fair and reasonable amount. Therefore, reimbursement is not recommended.
    - HCPCS Code A4550 – Surgical Trays. The requestor did not submit documentation to support that the amount billed is a fair and reasonable amount. Therefore, reimbursement is not recommended.
    - HCPCS Code J3490 – Unclassified drug. The requestor did not submit documentation to support that the amount billed is a fair and reasonable amount. Therefore, reimbursement is not recommended.
    - HCPCS Code S9445 – Patient Education. This codes is not covered under Medicare, Texas Medicaid does price this code; however, it is priced only in two instances: 1) Billed with modifier FP as services provided as part of a Medicaid Family Planning Program, or 2) as an Outpatient Behavioral Health-Chemical Dependency Treatment Facility. The requestor did not submit documentation to support these criteria. Therefore, this code will be reviewed under the Divisions fair and reasonable guidelines. The requestor did not submit documentation to support that the amount billed is a fair and reasonable amount. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $132.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $132.46 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 15, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.